

New Holstein Recreation

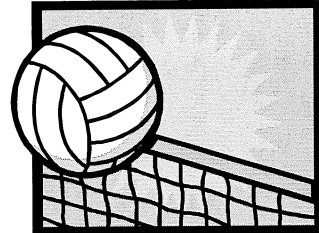
Girls 5th—6th Grade Volleyball

For Office Use Only:
 Shirt: Youth ___ Adult ___
 Paid CASH / Check # _____
 Amount Paid _____

This introductory program is for girls currently in grades 5 & 6, interested in learning and perfecting the fundamentals of volleyball. Basic beginner skills will be taught. Games will be played against teams in our surrounding area. Games are usually played on Mondays starting between the hours of 5-6PM. Practices will be determined by volunteer coaches availability and gym space and will run late August through October.

FEE: Resident \$35.00 (includes T-shirt)
 Non-resident \$40.00 (includes T-shirt)
 Return form and make check payable to City of New Holstein,
 2110 Washington St, New Holstein, WI 53061
 Now accepting credit cards (available at city hall or at www.ci.newholstein.wi.gov)

***Please fill out concussion form on
 reverse side before turning in.



Registration Deadline: August 14, 2017

(No team placement guaranteed after this date) (NO refunds given after first practice)

\$10 Late fee assessed after this date

Questions please contact Kim Olson at 920-795-4104

PLEASE PRINT

Players Name: _____

FIRST LAST

Current Grade: _____ (Girls entering grades 5-6)

Address: _____ City: _____ Zip: _____

Home Phone #: _____ **T-shirt Size** Youth _____ Adult _____

Parent Name: _____ Cell #1: _____

Email _____

Parent Name _____ Cell #2: _____

Email: _____

Coaches Needed!

Training for coaches will be provided. A background check is required and the application form is available at City Hall.

_____ **Yes, I would like to help coach. Name** _____ **Phone #** _____

Waiver of Liability & Insurance Information

Family Physician _____

List any special medical conditions/allergies that the coaches should be aware of:

List the names and phone numbers of persons who can be contacted during a game or practice in the event of an injury requiring emergency medical treatment:

Name	Phone #	Name	Phone #
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I hereby certify that my child is in good physical health and may participate in all recreational activities. I will not hold the City of New Holstein or Recreational Department Staff and volunteers responsible in the event of an accident/injury as a result of my child's participation in this recreational program. I also give permission for my child to be given emergency treatment at a local hospital.

 Parent or Guardian Signature

 Name of Parent or Guardian (Please print)

**City of New Holstein
Parent & Athlete Concussion Agreement**

As a Parent and as an Athlete it is important to recognize the signs, symptoms, and behaviors of concussions. By signing this form you are stating that you understand the importance of recognizing and responding to the signs, symptoms, and behaviors of a concussion or head injury.

PARENT AGREEMENT:

I _____ have read the Parent Concussion and Head Injury Information
(please print)

www.cdc.gov/concussion or http://sped.dpi.wi.gov/sped_tbi-conc-guidelines and understand what a concussion is and how it may be caused. I also understand the common signs, symptoms, and behaviors. I agree that my child must be removed from practice/play if a concussion is suspected.

I understand that it is my responsibility to seek medical treatment if a suspected concussion is reported to me.

I understand that my child cannot return to practice/play until providing written clearance from an appropriate health care provider to his/her coach.

I understand the possible consequences of my child returning to practice/play too soon.

Parent/Guardian

Signature _____ Date _____

ATHLETE AGREEMENT:

I _____ have read the Athlete Concussion and Head Injury Information
(please print)

www.cdc.gov/concussion or http://sped.dpi.wi.gov/sped_tbi-conc-guidelines and understand what a concussion is and how it may be caused.

I understand the importance of reporting a suspected concussion to my coaches and my parents/guardian.

I understand that I must be removed from practice/play if a concussion is suspected. I understand that I must provide written clearance from an appropriate health care provider to my coach before returning to practice/play.

I understand the possible consequence of returning to practice/play too soon and that my brain needs time to heal.

Athlete

Signature _____ Date _____

Questions and Contact Information

Name _____ Address _____

City _____ Zip _____ County _____ Phone _____

Email _____ Age _____ School Attending _____

Check all that apply

I participate in:

- | | | | | | |
|-------------------------------------|--|--|--|---------------------------------------|--|
| <input type="checkbox"/> Football | <input type="checkbox"/> Baseball/Softball | <input type="checkbox"/> Basketball | <input type="checkbox"/> Hockey | <input type="checkbox"/> Soccer | <input type="checkbox"/> Golf |
| <input type="checkbox"/> Volleyball | <input type="checkbox"/> Wrestling | <input type="checkbox"/> Track & Field | <input type="checkbox"/> Cross Country | <input type="checkbox"/> Cheerleading | <input type="checkbox"/> Skiing/Snowboarding |
| <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Tennis | <input type="checkbox"/> Swimming & Diving | <input type="checkbox"/> Other _____ | | |

Name of Current Team _____

1. Have you ever had a concussion? _____, if yes, how many? _____
2. Have you ever experienced concussion symptoms? _____ Did you report them? _____

Emergency Contacts:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____